Issue date: 12Dec2001**U.S. Department of Labor** Office of Administrative Law Judges
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CASE NO.: 1997-BLA-1827

In the Matter of

MARY GUMP Survivor of JAMES R. GUMP,
Claimant

v.

CONSOLIDATION COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

DECISION AND ORDER ON REMAND AWARDING BENEFITS

This proceeding arises from a now deceased miner's claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"). On July 31, 2001, the Benefits Review Board ("BRB") issued a Decision and Order, in the above-styled matter, affirming my award of benefits, in part, vacating it in part, and remanding it for further review. I received the record from the Board on October 5, 2001. In light of the fact the miner is deceased, I did not find a need to either reopen the existing record or set a further hearing. However, the parties were invited to submit briefs. The Solicitor declined to submit a brief, but the employer did.

The miner filed his claim on November 11, 1985. Administrative Law Judge Thomas Burke awarded benefits, on September 6, 1989.[1] The employer appealed the award.

This non-smoking miner with forty-seven years of coal mine employment died, on May 25,

[1] On October 31, 1994, Judge Leland denied benefits on the survivor's claim because the claimant had failed to establish pneumoconiosis had caused or substantially contributed to the miner's death.

1992. On April 8, 1993, the BRB affirmed the award of benefits, but remanded for a redetermination of the date of onset of the miner's total respiratory disability. The administrative law judge subsequently denied the employer's request for modification and determined the proper "onset" date was November 1984, based on Dr. Kristofic's report. The employer again appealed to the BRB which, on March 10, 1994, remanded the matter to the district director for modification proceedings. On August 23, 1995, the district director denied the request for modification. The employer requested a hearing. I was initially assigned the case on September 24, 1999 and, after continuances, held a hearing on March 8, 2000.

On April 24, 2000, I issued a Decision and Order Denying Employer's Request for Modification. I had accepted the parties' stipulation that the miner had coal worker's pneumoconiosis and that he suffered from a totally disabling respiratory disability.[2] The BRB found I had not weighed the opinion of Dr. Morgan when considering the issue of total disability due to pneumoconiosis and thus vacated my finding under 20 C.F.R. § 718.204(b)(2000). It also found I had "not set forth an adequate, independent rationale for (my) his apparent conclusion that the diagnosis of totally disabling COPD, related to coal dust exposure, made by Drs. Pinkerton, Gaziano, Silverman, Kristofic, and Martin, are reasoned and documented. The BRB held I had not addressed Dr. Pinkerton's comment that he would defer to pulmonary specialist Dr. Lapp's opinion. Further, the Board stated I had not resolved "the conflict between (my) his determination that Judge Leland properly found that coal dust exposure does not cause scleroderma and Dr. Pinkerton's more recent opinion that the miner's totally disabling impairment was related to coal dust inducted scleroderma."[3] The Board wrote,

> although the administrative law judge rationally found that Drs. Lapp, Fino, and Kleinerman did not explicitly address the presence of "legal" pneumoconiosis, he did not resolve the conflict between their determinations that the miner did not suffer from a disabling respiratory or pulmonary impairment until after he was diagnosed with scleroderma and the contrary opinions of Drs. Pinkerton, Gaziano, Kristofic, and Martin.

Finally, the Board determined I had not indicated what weight, if any, I gave Dr. Renn's conclusion that "the respiratory impairment that the miner experienced during his lifetime was due to scleroderma, rather than coal workers' pneumoconiosis or industrial bronchitis" or indicate I considered Dr. Naeye's explanation that "the cause of the emphysema could not be attributed to coal dust exposure."

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[2] The parties had also so stipulated in the survivor's claim.

[3] I had framed the issue in my D&O as "Whether in the living miner's claim, a mistake of fact was committed in finding the miner was totally disabled due to pneumoconiosis when it was found in the survivor's claim that the miner died from scleroderma and the coal dust exposure did not contribute to the miner's scleroderma?" Dr. Pinkerton's most recent opinion, expressed in a deposition of March 16, 1994, predated Judge Leland's October 31, 1994 D & O in the survivor's claim and was considered by Judge Leland. (ALJ Leland D & O, page 8).

Thus, the Board remanded for a determination of whether the employer had established a mistake of fact with respect to whether the pneumoconiosis was a substantial contributor to the miner's totally disabling respiratory impairment, under section 718.204(b)(2000).

THE LAW[4]

This proceeding arises from a miner's claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"). The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers pneumoconiosis" "CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[5] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

" . . . [T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'"

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[4] My earlier finding that the law of the Third Circuit applies was not contested.

[5] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases . . . attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See*, e.g., *Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing*, *Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980).[6]

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

Under 20 C.F.R. § 725.310, a modification petition may be based upon a mistake of fact or a change in conditions.[7] In determining whether a mistake of fact has occurred, the Administrative Law Judge is not limited to a consideration of newly submitted evidence. All evidence of record may be reviewed to determine whether a mistake of fact was previously made. *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256, 92 S.Ct. 405, 407, 30 L.Ed.2d 424 (1971)(per curiam)(decided under Longshore and Harbor Workers' Compensation Act). The Administrative Law Judge has "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence previously submitted." *O'Keefe*, 404 U.S. 254 at 257; *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1364 (4th Cir. 1996)(*en banc*), *quoting Jessee v. Director, OWCP*, 5 F.3d 723, 724 (4th Cir. 1993). Therefore, a complete review of the record will be conducted to determine whether a mistake of fact exists.

The Third Circuit requires pneumoconiosis be a "substantial contributor" to the miner's total disability. *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 734, 13 B.L.R. 2-23 (3d Cir. 1989). The Board requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990)(*en banc), overruling Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However,

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[6] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases . . . attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See*, e.g., *Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

[7] 20 C.F.R. 725.310 (2001)(Applicable only to petitions for modification filed on or after Jan. 19, 2001). (65 Fed. Reg. 80057).

where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[8] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

There is a distinction between a physician who merely examines a miner and one who is one of his "treating" physicians.[9] Dr. Pinkerton was Mr. Gump's treating physician for over seven years. As such, his opinion would ordinarily be entitled to more weight as he was more familiar with the miner's condition than a physician who examined him episodically. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989); *Jones v. Badger Coal Co.*, 21 B.L.A. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*)(Proper for judge to accord greater weight to treating physician over non-examining doctors).[10]

THE FACTS[11]

Pulmonary Function Studies

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

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[8] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp*., 6 B.L.R. 1-1291 (1984). . ."

[9] "Treatment" means "the management and care of a patient for the purpose of combating disease or disorder." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 1736 (28th Ed. 1994). "Examination" means "inspection, palpitation, auscultation, percussion, or other means of investigation, especially for diagnosing disease, qualified according to the methods employed, as physical examination, radiological examination, diagnostic imaging examination, or cystoscopic examination." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 589 (28th Ed. 1994).

[10] *Lango v. Director, OWCP*, 104 F.3d 573 (3d Cir. 1997). The Court wrote that while there is "some question about the extent of reliance to be given a treating physician's opinion when there is conflicting evidence, *compare Brown v. Rock Creek Mining Co.*, 996 F.2d 812, 816 (6th Cir. 1993)(opinions of treating physicians are clearly entitled to greater weight than those of non-treating physicians) *with Consolidation Coal Co. v. OWCP*, 54 F.3d 434, 438 (7th Cir. 1995)(improper to favor opinion of treating physician over opinions of non-treating physicians)," a judge may require "the treating physician to provide more than a conclusory statement (before finding pneumoconiosis contributed to the miner's death)."

[11] I adopt the facts set forth in the prior decisions except in so far as they are inconsistent with those set forth herein.

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Tra-cings**	**Compre-hension Cooper-ation**	**Qualify * Conf-orm****	**Dr.'s Impression**
Mon General 3/9/81 DX 110	58 60"	1.98 2.11+	58 75+	2.74 2.82+			No* No*	Dr. Morgan's testimony casts doubt on the validity of these tests. (Dep. 17).
CAMC 7/21/81 DX 37	59 61"	2.46	142	3.26	Yes		No*	
Kristofic 11/23/84 DX 17	62 61"	1.60 1.70+	94 107+	2.10 1.90+	Yes	Good	No* No*	Moderate obstructive pulmonary disease. Dr. Morgan disagrees. (Dep. 20).
Garson 12/9/85 DX 16	63 62"	1.88 1.90+	51 107+	2.53 1.70+	Yes	Good	No* No*	Dr. Morgan pointed out that if the height is wrong the predicted values would also be wrong. (Dep. 24).
Abrahams 6/25/86 DX 51, 110	63 66"	2.07 2.16+	54 53+	2.87 2.80+	Yes	Good	No* No*	Moderate small airways disease.
Renn 5/20/87 DX 50, 110	64 64"	2.18 2.38+	98 113+	2.99 3.04+	Yes	Good	No* No*	Suboptimal technical quality. Minimal obstructive ventilatory defect.

* A "**qualifying"** pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable quality standards (found in 20 C.F.R. § 718.103(b) and (c)). (*see Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993)). A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

+Post-bronchodilator.

Appendix B (Effective for tests on or after Jan. 19, 2001) states: "(2) The administration of pulmonary function tests shall conform to the following criteria:

(i) Tests shall not be performed during or soon after an acute respiratory illness. . ."

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive

variability between the three acceptable curves. The variation between the two largest FEV1's of the three acceptable tracings should not exceed 5 percent of the largest FEV1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve this degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

For a miner of the claimant's height of 61 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.28 for a male 64 years of age.[12] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 1.66 or an MVV equal to or less than 51; or a ratio equal to or less than 55% when the results of the FEV1 test are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	Age	FEV_1	FVC	MVV
60"	58	1.28		
61"	58	1.37		
61"	59	1.36		
61"	62	1.31		
61"	63	1.29		
62"	63	1.36		
66"	63	1.67		
61"	64	1.28		
62"	64	1.34		
64"	64	1.50		

[12] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 43 F.3d 3 (4th Cir. 1995). I find the miner is 61" here, his median reported height.

C. Arterial Blood Gas Studies[13]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange.[14] This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex.#	**Physician**	**PCO_2**	**PO_2**	**Qualify**	**Physician Impression**
2/8/84 DX 110	Mon Gen.	18	91	No	
11/23/84 DX 22	Kristofic	24.2 32.5+	73.3 56.3+	Yes Yes+	
6/14/85	Kaplan	22.6	92.7	No	
1/10/86 DX 24, 26	Garson	27.3	105.9	No	
2/17/86 DX 24	Parkinson	35.0	60.0	Yes	
6/25/86	Pinkerton	24.0	81.0	No	Respiratory alkalosis.

[13] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. § 718.204(b)(2) permits the use of such studies to establish "total disability." It provides:
In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability: . . .
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part . . .

[14] 20 C.F.R. § 718.105(d) (Applicable Jan. 19, 2001) states:
"If one or more blood-gas studies producing results which meet the appropriate table in Appendix C is administered during a hospitalization which ends in the miner's death, then any such study must be accompanied by a physician's report establishing that the test results were produced by a chronic respiratory or pulmonary condition. Failure to produce such a report will prevent reliance on the blood-gas study as evidence that the miner was totally disabled at death."

[(e) In the case of a deceased miner, where no blood gas tests are in substantial compliance with paragraphs (a), (b), and (c), noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the only available tests demonstrate technically valid results. This provision shall not excuse compliance with the requirements in paragraph (d) for any blood gas study administered during a hospitalization which ends in the miner's death.]

Date Ex.#	Physician	PCO_2	PO_2	Qualify	Physician Impression
12/23/86 DX 110	Mon Gen	30	63	Yes	
5/20/87 DX 110	Renn	24	63	Yes	
6/27/91 DX 110	Mon Gen	29 38 38 35 35	157 129 83 267 82	No No No No No	Done during hospitalization.
6/28/91 DX 110	Mon Gen	44	73	No	Done during hospitalization.
10/26/91 DX 110	Mon Gen	34	66	Yes	
3/31/92 DX 110	Mon Gen	30 30	63 68	Yes Yes	

+ Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b). Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

DISCUSSION OF FACTS AND LAW

I first dispose of the Board's statement that I had not resolved "the conflict between (my) his determination that Judge Leland properly found that coal dust exposure does not 'cause' scleroderma and Dr. Pinkerton's more recent opinion that the miner's totally disabling impairment was related to coal dust inducted scleroderma."[15] (Emphasis added). My earlier decision was that I had agreed with Judge Leland that the miner's scleroderma was not caused by the miner's coal mine employment coal dust exposure, accepting his reasoning. Judge Leland had explained why the opinions of Drs. Pinkerton and Parkinson, who found an association between scleroderma and coal dust exposure, did not establish scleroderma as "legal" pneumoconiosis given the contrary opinions of Drs. Morgan,

[15] The Board has defined scleroderma as a musculoskeletal problem which also effects the cardiovascular system. The claim was remanded for further medical evaluation. *Collins v. J & L Steel (LTV Steel)*, 21 B.L.R. 1-182 (1999). "Chronic hardening and shrinkage of the connective tissues of any part of the body, including the skin, heart, esophagus, kidney, and lung." DORLAND'S POCKET MEDICAL DICTIONARY, 23rd. Edition. (1982).

Kleinerman, Lapp and Renn.[16] Since, I had agreed scleroderma, which was first diagnosed in 1991, was not "legal" CWP, there was no further need to reconcile that which had already been resolved.[17]

On December 2, 1997, Judge Burke wrote that he did not believe it was necessary, in denying the employer's request for modification, to address the etiology of the miner's scleroderma, first diagnosed in 1991, when he had first found total disability due to CWP in 1989 and again in 1993. He wrote, "the record supports a finding that while scleroderma furthered the claimant's impairment, it was not the sole cause of it." He also found the role of scleroderma in the miner's demise irrelevant to the case before him.[18]

This non-smoking miner retired from coal mining in 1984 because he could no longer work due to breathing problems. I find it most probative that the miner's scleroderma was not diagnosed until 1991. Furthermore, the employer's expert, Dr. Morgan, found it to be "rapidly progressing" and "more rapid than most." In fact, the miner died in May 1992. Dr. Morgan found the miner's lung function "normal" until he developed scleroderma, which he found to be in the early 1990's. Dr. Kleinerman categorized the 1981 and 1987 PFSs as "entirely normal" and found no lung disease from coal mining between 1981 and 1987 per the PFSs.[19] Moreover, Dr. Renn, who also sees no relationship between scleroderma and coal mine dust exposure, believed the miner's PFSs changed from 1987 through 1991 due to scleroderma, not the results of coal mine dust exposure. I note that he was wrong twice not diagnosing CWP when it had been previously diagnosed. Dr. Gaziano found no scleroderma in the early to mid-1980's. In 1988, Dr. Fino found insufficient evidence to diagnose CWP and found no respiratory impairment, however, he lacked Dr. Pinkerton's records to review, according to Judge Burke. Then, in 1993, Dr. Fino diagnosed clinically insignificant simple CWP. In 1994, Dr. Lapp found the miner's interstitial fibrosis was explained by his scleroderma and a shunt problem with oxygen exchange. While the miner's PFS were all "non-qualifying", under the regulations, he had "qualifying" AGS between 1984 and 1991.[20] Under the regulations, those "qualifying" AGS are

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[16] In reaching his conclusion about the association between scleroderma and coal mine dust, Dr. Pinkerton had relied on books and articles by Drs. Lapp and Morgan among others, both of the former found the interpretation of their writings incorrect. Interestingly, during his deposition, Dr. Morgan attacked, to some degree, the conclusions in his very own book concerning the association between scleroderma and silicosis and coal mine dust. (Dep. 39-45). Moreover, he would not have denied the association in this case had there been obvious X-ray evidence of silicosis rather than the minimal amount shown on biopsy. (Dep. 46). He admitted he did not know whether there had been any positive X-ray readings in Mr. Gump's case.

[17] Upon further reflection, I observe there is certainly very good evidence concerning the relationship of PSS/scleroderma to silica exposure, but, given the contrary testimony in this case, a direct causal relationship is not established.

[18] On December 18, 1998, the Board vacated the Denial of Modification and remanded the case solely because the judge had not afforded the employer the opportunity for a hearing.

[19] However, he did not explicitly acknowledge Dr. Renn's observation that the 1987 PFS was technically suboptimal.

[20] All the AGS results are set forth above in a table. The "non-qualifying" AGSs of June 1991 were performed during hospitalizations when the miner was on supplemental oxygen and thus have little value. (DX 110).

evidence of total disability. The existence of those qualifying AGS and physician opinions finding lung function impairment show the aforesaid opinions finding no respiratory impairment until 1987 or after were incorrect.

Dr. Pinkerton explained Mr. Gump had, since 1988, a consistent hyperventilatory blood gas pattern and possibly a decreased DLCO, most commonly associated with PSS. He was always tachypneic and dyspneic and needed to hyperventilate to maintain a normal PO2. (Dep. 46, 48). He admitted, Dr. Renn's 1987 DLCO had normal diffusion. All of Dr. Pinkerton's examinations of the miner revealed chest abnormalities. (Dep. 50). Mr. Gump was always out of breath on exertion. (Dep. 50). Dr. Martin believed the "qualifying" AGS were due to his COPD, in part. (DX 21). Dr. Kleinerman opined the variation in blood gases could be due to scleroderma, rheumatoid arthritis with interstitial fibrosis, or pulmonary hypertension. (Dep. 24-25). He felt the inconsistent PO2 results could not be from CWP. However, Dr. Kleinerman did not specifically rule out the miner's other diagnosed coal mine dust induced respiratory afflictions were precluded from such variability. Dr. Parkinson noted those with the very rare disease of scleroderma or PSS frequently have a problem with the transmission of gases across the lung. (Dep. 15). Moreover, the miner's documented symptoms are far more consistent with a total respiratory disability as indicated by "qualifying" AGS's than either the "non-qualifying" AGS or PFSs.

Setting aside scleroderma, Drs. Pinkerton, Silverman, Kristofic, and, Martin, all made pre-1991diagnoses of: CWP, COPD, emphysema, bronchial asthma, anthrasilicosis, bronchitis, pulmonary fibrosis from coal mine dust exposure, usual interstitial pneumonitis with fibrosis, restrictive lung disease, and chronic asthmatic bronchitis. Specifically, the following were said to be caused by or related to the miner's coal mine dust exposure: pulmonary fibrosis from coal mine dust exposure, CWP, COPD, emphysema, bronchial asthma, anthrasilicosis, bronchitis. Later, Dr. Pinkerton diagnosed: reactive airways and industrial bronchitis from coal mine dust exposure. Drs. Parkinson and Pinkerton believed the progressive fibrosis was caused or triggered by coal dust exposure.[21] Dr. Pinkerton did not say scleroderma was "caused" by coal mine dust exposure, but rather that it was highly likely it triggered an immune response causing progressive fibrosis.[22] (See also Dep. pp 37-38). Likewise, Dr. Parkinson did not say scleroderma was "caused" by coal mine dust exposure, but rather that it was a major contributing factor for the interstitial fibrosis and scleroderma.

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[21] Dr. Pinkerton testified, "Mr. Gump developed a chronic progressive pulmonary disorder related to his coal dust exposure that manifested itself, in his particular case, as a progressive systemic sclerosis (PSS) pattern of disease. . . I wanted (by using PSS versus scleroderma) to demonstrate that this is an entity which is not reflected in the name scleroderma. . . There is a high likelihood that Mr. Gump's exposure to coal dust elicited a pathologic immune response in his system that caused a progressive fibrosis of his lungs (as does black lung diseases) to a disabling progressive degree . . . through the mechanism of scleroderma." (Dep. 19, 22, 56, 58).

[22] Despite counsel seeking to have Dr. Pinkerton say scleroderma was "caused" by coal dust exposure, the doctor persistently and carefully did not use those words himself. (See, for example Dep. p. 42 and 51).

Drs. Kleinerman, Morgan and Renn all opined scleroderma was not caused by coal mine dust exposure. Drs. Kleinerman, Renn and Lapp did not believe the interstitial fibrosis was due to coal mine dust exposure, but rather the scleroderma itself. Unlike the apparent precision of these three, of which I am skeptical, Drs. Pinkerton and Parkinson did not attribute the pulmonary fibrosis solely to scleroderma.[23] However, while focusing on the cause of death, clinical CWP and scleroderma, most of the employer's experts did not explicitly discuss why they would rule out the miner's other respiratory afflictions, i.e., pulmonary fibrosis from coal mine dust exposure, CWP, COPD, emphysema, bronchial asthma, anthrasilicosis, bronchitis, reactive airways disease and industrial bronchitis from coal mine dust exposure.[24] Nor did they explicitly address and rule out the respiratory diagnoses, arising out of coal mine dust exposure, between 1981 and 1987, i.e. pulmonary fibrosis from coal mine dust exposure, CWP, COPD, emphysema, bronchial asthma, anthrasilicosis, and bronchitis. If anything, they avoid explicit discussion of specific potential coal mine dust induced diseases, other than clinical CWP, and merely attribute Mr. Gump's respiratory impairment to scleroderma or a shunt problem with oxygen exchange.

Dr. Renn had diagnosed chronic bronchitis in 1982. Dr. Naeye opined the moderate to severe emphysema was not due to coal mine dust exposure but did not provide an etiology, but Drs. Martin and Pinkerton found the emphysema was due to coal mine dust exposure. Dr. Kleinerman found no coal mine dust related disease between 1981 and 1987. No one diagnosed the existence of this rapidly progressing scleroderma between 1984, when the miner retired, and 1987. This was also a period in which the miner had five "qualifying" AGSs (but no "qualifying" PFSs). In 1981, Dr. Rhudy had diagnosed CWP, mild obstructive lung disease and hyperventilation. Mon General records of 3/2/81 diagnose CWP, hyperventilation, and mild obstructive and restrictive pulmonary disease. Records of 6/20/81 diagnose hyperventilation and mild COPD, as do records of 2/8/84.

It is significant the Board agreed with me that Drs. Lapp, Fino, and Kleinerman had not explicitly addressed the presence of "legal" pneumoconiosis. In light of all this, I conclude Dr. Kleinerman was wrong in his determination the miner had no lung disease from coal mining between 1981 and 1987. Likewise, I find Dr. Morgan's assessment that the miner had "normal" lung function

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[23] Despite their attempted explanations, I do not accept the fact that physicians can distinguish between pulmonary fibrosis caused by scleroderma and that caused by coal mine dust exposure in a case such as this, with a non-smoking, totally disabled miner with forty-seven years of significant coal mine dust exposure. Moreover, Dr. Morgan's attack on his own published conclusions gives rise to skepticism when coupled with his reliance solely on the negative X-ray readings.

[24] The fact that their reports or testimony indicate familiarity with other diagnoses constituting "legal" CWP, does not equate with a thorough discussion of why they ruled out such afflictions and their contribution to the miner's disability. Nor does attributing the entire respiratory disability to scleroderma constitute a reasoned discussion of why the other diagnoses constituting "legal" CWP did not contribute to the miner's disability. My lax use of the term "consider" in my earlier decision was not totally appropriate.

until he contracted scleroderma was wrong.[25] I would have to ignore several physician opinions, set forth above, the AGS results, and more importantly, the miner's symptoms, and his treating physician's opinion to find Drs. Morgan, Fino, Lapp and Kleinerman's conclusions valid. Moreover, since the miner did not have scleroderma when many of the initial diagnoses were made, the fact several of those physicians did not consider the effects of scleroderma is unimportant.

Dr. Pinkerton, who is board certified in internal medicine, was the miner's treating physician from 1985 until his death. He examined the miner over twenty times seeing him about every three to six months or more from 1985. (Dep. 59). Moreover, he had the benefit of reviewing his former partner's (Dr. Rhudy) office notes of prior treatment, as well as reviewing Drs. Fino's and Naeye's reports.[26] Dr. Pinkerton attributed the miner's symptoms during that period to bronchitis and a progressive pulmonary impairment from coal mine dust exposure. He, like Dr. Parkinson, who is Board-certified in Occupational Medicine, did not say the miner's fibrosis was not due to scleroderma.[27] Nor did Drs. Pinkerton and Parkinson say the fibrosis was exclusively due to coal mine dust exposure.[28] Rather, they opined essentially that the coal mine dust exposure contributed to it.[29] This is unlike the apparently more dogmatic view held by the employer's experts (other than Dr. Lapp) who ruled out coal mine dust exposure as a contributing factor to the miner's fibrosis. Moreover, Dr. Pinkerton's response to the employer's counsel's question that he would welcome Dr. Lapp's opinion does not mean much of anything.[30] (DX 110, Pinkerton Deposition at page 38). I give great weight to Dr. Pinkerton's well-reasoned and documented opinion.

I find it significant that several physicians listed diagnoses apart from or in addition to scleroderma. For instance, Dr. La Mata, who conducted the 1991 biopsy, diagnosed simple CWP

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[25] Dr. Morgan had observed "[T]here were a number of so called abnormal results from spirometry, and in all of these Mr. Gump had made a submaximal effort and the effort had not been sustained." (EX 3). Dr. Renn had found his own PFS technically suboptimal. Dr. Morgan admitted he was unaware of any positive X-ray readings and had relied only on the negative readings of readers familiar to him.

[26] He vehemently disagreed with Dr. Fino's conclusion that Mr. Gump would have died in the same manner and the same time even if he had not stepped foot in a coal mine. (Dep. 36).

[27] Dr. Parkinson is specialized in epidemiology, unlike any other physician of record. (Dep. 13-14). Moreover, he testified that researchers like Drs. Lapp and Kleinerman do not usually have such training. (Dep. 41).

[28] In his March 1994 deposition, Dr. Pinkerton testified one cannot say scleroderma is caused by a specific entity. (Dep. 9). Dr. Parkinson likewise pointed to a "significant relationship" between the disease processes and the statistically significant incidence of scleroderma in coal miners and the contribution of coal dust to the disease. (Dep. 20, 23, 49).

[29] Dr. Parkinson testified on cross-examination that "there is general acceptance. . . that silica . . . dust exposure will cause an increase in Progressive Systemic Sclerosis, but we do not know yet what the mechanism is." (Dep. 59-60, 63).

[30] The language used by the Board to characterize this, i.e., "deferring" to Dr. Lapp, is an exaggeration repeated from language in the employer's appellate brief..

and usual interstitial pneumonitis. Dr. Gaziano found the miner was disabled by CWP in the 1980's, even though his later death was due to scleroderma. Dr. Pinkerton listed industrial bronchitis, emphysema, reactive airways disease all from coal mine dust exposure, in addition to scleroderma. Dr. Parkinson listed silicosis in addition to scleroderma. Dr. Gainer, who was involved with the miner's last hospital admission, listed COPD and CWP as other significant conditions in addition to scleroderma on the death certificate and his discharge diagnosis. Mon General records of 6/26/91, 11/1/91 and 4/24/92 reflect diagnoses of interstitial fibrosis, pulmonary fibrosis, pneumonitis, COPD, CWP, and restrictive pulmonary disease in addition to scleroderma.

It is further established that the miner was sixty-two years old when he left coal mining because he did not feel he could continue working due to his breathing problems. Dr. Pinkerton wrote, in 1986, the miner reported he was "totally incapacitated" at the time. This non-smoking miner became short of breath upon minimal exertion. He was hospitalized as early as 1981 for progressive dyspnea. Thus, the diagnoses reflecting pulmonary impairment were far more consistent with the miner's actual symptoms and more credible than those finding no impairment until scleroderma was diagnosed.

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I rank Drs. Gaziano, Martin, Pinkerton, Parkinson, Kleinerman, Renn, Fino, Naeye, Morgan, and Lapp more or less equally. Dr. Parkinson had specialized experience treating miners and training in epidemiology. (Dep. 18). However, Drs. Fino, Lapp, Morgan, Naeye, Gaziano, Kleinerman, and Parkinson had not examined the miner, unlike Drs. Pinkerton, Renn, Martin, Kristofic, and Abrahams.[31] There is a distinction between a physician who merely examines a miner and one who is one of his "treating" physicians.[32] Dr. Pinkerton was Mr. Gump's treating physician for seven years. As such, his opinion is entitled to more weight as he was more familiar with the miner's condition than those physicians who examined him episodically (or not at all).[33] *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989); *Jones v.*

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[31] Obviously, pathologists are not expected to examine the living miner, but often have the opportunity to perform an autopsy. The fact they did neither here, tends to give the lifetime, treating, examining physician somewhat more credence in assessing the miner's lifetime condition.

[32] "Treatment" means "the management and care of a patient for the purpose of combating disease or disorder." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 1736 (28th Ed. 1994). "Examination" means "inspection, palpitation, auscultation, percussion, or other means of investigation, especially for diagnosing disease, qualified according to the methods employed, as physical examination, radiological examination, diagnostic imaging examination, or cystoscopic examination." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 589 (28th Ed. 1994).

[33] § 718.104(d) Treating physician (Jan. 19, 2001). In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was, totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's

Badger Coal Co., 21 B.L.A. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*)(Proper for judge to accord greater weight to treating physician over non-examining doctors).[34]

I do not give much credit to Dr. Renn because he failed to diagnose CWP twice and, more importantly, as late as 1987, found the miner was not disabled, in spite of Dr. Pinkerton's observations and the miner's own testimony, which leave little, if any doubt the miner was totally disabled from performing his coal mine work.[35] The same is true of Dr. Fino, who failed to diagnose CWP, in 1988, and, more importantly, found the miner was not disabled from coal mining. Mr. Gump was diagnosed as early as March 11, 1981 with clinical CWP. (See DX 110). Moreover, Dr. Pinkerton exhibited the highest degree of familiarity with the miner's work history followed by Dr. Parkinson. (Dep. 74).

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treating physician:

(1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) Duration of relationship. The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

(3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

(4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) In the absence of contrary probative evidence, the adjudication officer shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

[34] *Lango v. Director, OWCP*, 104 F.3d 573 (3d Cir. 1997). The Court wrote that while there is "some question about the extent of reliance to be given a treating physician's opinion when there is conflicting evidence, *compare Brown v. Rock Creek Mining Co.*, 996 F.2d 812, 816 (6th Cir. 1993)(opinions of treating physicians are clearly entitled to greater weight than those of non-treating physicians) *with Consolidation Coal Co. v. OWCP*, 54 F.3d 434, 438 (7th Cir. 1995)(improper to favor opinion of treating physician over opinions of non-treating physicians)," a judge may require "the treating physician to provide more than a conclusory statement (before finding pneumoconiosis contributed to the miner's death)."

But see, Sterling Smokeless Coal Co. v. Akers, 131 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997), wherein the Court held that a rule of absolute deference to treating and examining physicians is contrary to its precedents. *See also, Amax Coal Co. v. Franklin*, 957 F.2d 355 (7th Cir. 1992) where the court criticized the administrative law judge's crediting of a treating general practitioner, with no apparent knowledge of CWP and no showing that his ability to observe the claimant over an extended time period was essential to understanding the disease, over an examining Board-certified pulmonary specialist bordered on the irrational. The Court called judge's deference to the "treating physician" over a non-treating specialist unwarranted in light of decisions such as *Richardson v. Perales*, 402 U.S. 389, 91 S.Ct. 1420, 28 L.Ed.2d 842 (1971); *Garrison v. Heckler*, 765 F.2d 710, 713-15 (7th Cir. 1985); and, *DeFrancesco v. Bowen*, 867 F.2d 1040, 1043 (1989).

[35] While I recognize that the 1991 biopsy confirmed the existence of CWP and the variety of X-ray readings before that, I observe that CWP had, in fact, been nonetheless diagnosed several times earlier. In light of the regulatory provision that negative X-ray readings do not preclude an award of benefits, I recognize the negative X-ray is often of limited value.

To reiterate, Dr. Kristofic had examined the miner, reviewed his occupational and medical history, performed an examination, and had an X-ray, PFS, AGS and EKG taken. Dr. Martin had examined the miner, reviewed his occupational and medical histories, and had an X-ray, PFS, and AGS performed. Dr. Silverman had examined the miner, reviewed his occupational and medical histories, and had an X-ray, EKG and PFS performed. Dr. Pinkerton had repeatedly examined the miner, reviewed his occupational and medical history, and had X-rays, PFSs, and AGSs taken. Dr. Renn had examined the miner, reviewed his occupational and medical history, and had an X-ray, PFS, AGS and EKG taken. Dr. Fino did not examine the miner but reviewed his medical records. Neither Dr. Kleinerman nor Dr. Morgan examined the miner, but both reviewed his medical records. Dr. Gaziano had not examined the miner, but reviewed his medical records. The opinions of Drs. Pinkerton, Parkinson, Martin, Gainer, and, Gaziano are essentially consistent with one-another. The opinions of Drs. Kleinerman, Renn, Naeye, Morgan, Fino and Lapp. For the reasons above, among others highlighted herein, I find their opinions both reasoned and documented.

The evidence establishes that earliest this non-smoking miner could have had scleroderma was in 1987. Prior to contracting scleroderma, it is established he suffered from CWP, COPD, pulmonary fibrosis, chronic industrial bronchitis, bronchial asthma, emphysema, anthrasilicosis, bronchitis, all due to coal mine dust exposure. Prior to his 1991 scleroderma diagnosis, he was found to also suffer from a significant lung disease with a bronchospastic asthma-like component by Dr. Pinkerton.

Thus, the reasons Judge Burke set forth in his 1998 D & O to find the miner totally disabled due to CWP with an onset of November 1984 were and remain valid. The evidence does not establish that the disability found by Judge Burke, in 1998, was due to scleroderma. There is little doubt that scleroderma played a major role in the miner's respiratory disability sometime after 1987. However, when scleroderma appeared in 1987 - 1991, the miner's other respiratory afflictions had not vanished. His COPD, industrial bronchitis, asthmatic bronchitis, pulmonary fibrosis, anthrasilicosis, CWP, usual interstitial pneumonitis, and emphysema continued to plague him and substantially contribute to his total respiratory disability.

CONCLUSIONS

It is established that Mr. Gump, who was a non-smoker with 47 years of coal mine dust exposure, suffered from "legal" pneumoconiosis, including silicosis, as well as "clinical" CWP prior to his death. As Judge Burke found he suffered from a total respiratory disability with a November 1984 onset date. His clinical CWP did not significantly contribute to his total respiratory disability. But, it is proven his "legal" CWP, as described above, did so contribute. While the development of scleroderma may be attributed to coal mine dust and silica exposure, given the contrary evidence in this case, I do not find it is caused by coal mine dust exposure. The "legal" CWP from which Mr. Gump suffered, as early as 1984, did not disappear after he was found to suffer from scleroderma. Nor is it

established that scleroderma rather than coal mine dust induced "legal" CWP was the reason for his total respiratory disability at that early time. Thus, Mr. Gump was totally disabled from pneumoconiosis during his lifetime and is entitled to an award of benefits.

ORDER

WHEREFORE, IT IS ORDERED THAT the claimant, Mrs. Mary Gump on behalf of Mr. James R. Gump, is entitled to benefits.

A
RICHARD A. MORGAN
Administrative Law Judge

RAM:dmr